Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
2 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

HISTORY   INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT   [ ]   Breast Feeding   [ ]   Formula (type) _____
         Supplements: [ ]   Fluoride   [ ]   Vitamins   [ ]   Iron
SENSORY ASSESSMENT   Vision: Within normal limits?   [ ]   Yes   [ ]   No, Refer
                Hearing: Within normal limits?   [ ]   Yes   [ ]   No, Refer
DEVELOPMENTAL ASSESSMENT   Age appropriate?   [ ]   Yes   [ ]   No
     Vocalizes reciprocally, smiles responsively, attentive to voices, when prone-lifts head, neck, upper chest.
     (If suspicious, do specific objective testing) Assessment Tool (name) _____

T _____
P _____
R _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes (red reflex)		
Ears (symmetrical)		
Nose		
Mouth/Throat		
Nodes		
Heart		
Lungs		
Abdomen		
Fem. Pulse		
Ext. Gen.		
Hip Abduc.		
Extremities		
Spine		
Neuro		
Other		

LAB/SCREENING

Hct./Hgb.		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed?   [ ] Yes   [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today?   [ ] Yes   [ ] No
Is there a current immunization record in the medical chart?   [ ] Yes   [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Nutrition
[ ] Sleep positioning/practices
[ ] Fever education

[ ] Family relationships
[ ] Other child care providers
[ ] Talk to baby
[ ] Pacifiers, bottle tooth decay

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)?   [ ] Yes   [ ] No